WALES MENTAL HEALTH in PRIMARY CARE (WaMH in PC)

Bursary Bid 2010

North Wales Community Adult Eating Disorders Service (CAEDS),
Betsi Cadwaladr University and Powys Teaching Health Boards

CAEDS will make its application for a WaMH in PC bursary under Category 1: *Enabling recovery and social inclusion*

AUDIO-BASED MEAL SUPPORT FOR INDIVIDUALS WITH EATING DISORDERS

Aim of the project:

To develop an audio-based form of meal support (and accompanying booklet) that will be used within CAEDS and disseminated to local primary care practitioners with the aim of facilitating individuals with eating disorders to re-establish healthy patterns of eating. To contribute to the current research regarding the effectiveness of such a tool in helping individuals with eating disorders establish healthy eating patterns.

If successful, the WaMH in PC Bursary would be used to:

Purchase MP3s and pay for hire of recording equipment to produce audio-based meal therapy
Fund production of accompanying booklets for carers
Fund translation expenses for all content
Fund leaflets for advertising the audio files in primary care services

Betsi Cadwaladr and North Powys Health Boards, Community Adult Eating Disorders Service (CAEDS)
Bryn Y Neuadd Hospital, Llanfairfechan, Conwy, LL33 0HH. **Telephone:** 01248 682610 Email: Tanya.owens@wales.nhs.uk (administrator)
Betsi Cadwaladr: Cyhfeiriad Gohebiaeth ar gyfer y Cadeirydd a'r Prif Weithredwr / Correspondence address for Chairman and Chief Executive: Swyddfa'r Gweithredwyr, Ysbyty Gwynedd, Bangor, LL57 2PW
Gwefan: www.pbc.cymru.nhs.uk / Web: www.bcu.wales.nhs.uk

BACKGROUND

The diagnosis of 'eating disorder' is given when a person's preoccupation with food and / or weight beings to interfere with their daily life and physical health. In Anorexia Nervosa, for example, the person's extreme fear of gaining weight leads him or her to restrict their nutritional intake to such a degree that he or she is classified as underweight; in Bulimia Nervosa, an individual maintains a weight within healthy levels but engages in physically damaging behaviour around food and eating such as 'bingeing' and vomiting after eating.

As well as serious physical complications (including loss of fertility, decreased brain volume, osteoporosis; NICE, 2004), eating disorders are often accompanied by extreme psychological difficulties. They often emerge with significant psychiatric co-morbidities such as depression, anxiety disorders, alcoholism, post traumatic stress disorder and panic (National Institute for Clinical Excellence (NICE), 2004). Significantly, anorexia nervosa has been observed as having the highest mortality rate of any psychiatric condition (around three times higher), through suicide and physical complications such as cardiovascular failure (NICE, 2004).

The prognosis for individuals with eating disorders is rather variable; while, with effective treatment such as guided self-help, approximately 50% people can be classified as 'recovered' from bulimia nervosa 2 – 10 years after assessment (NICE, 2004), a summary of the prognosis of anorexia nervosa has found that 43 per cent were classified as having recovered completely, 36% had improved, 20% were living with their eating disorder chronically and 5% had died from complications resulting from the eating disorder or from suicide (NICE, 2004).

Owing to the severity of these disorders, the Welsh Assembly Government made available funds to establish four community-based eating disorder services in Wales. The North Wales Community Adult Eating Disorders Service (NW CAEDS) covers seven counties across north Wales, including North Powys, serving a population of approximately half a million adults. The service has five and a half full-time equivalent clinicians in post, and has received 70 referrals since May 2010. We work primarily with individuals with elevated physical risk, but are working to increase our capacity to work with any individual who comes to us with an eating disorder. In order to do this given our huge geographical catchment area and small team of clinicians we are having to develop novel tools and techniques, particularly those that can be used by individuals relatively independently in their own time. This has the benefit of promoting the individual's own skills rather than being dependent on the availability of clinicians and services.

In terms of established methods of treatment, there is currently no specifically recommended treatment for anorexia nervosa. For bulimia nervosa, the first line of treatment recommended is guided self-help, based on Cognitive Behavioural Therapy principles (NICE, 2004). For both types of eating disorder, an important therapy goal is to re-establish as healthy an eating pattern and relationship with food and / or weight as possible. This usually includes re-establishing eating balanced, healthy meals at appropriate times of the day. However, this is often very frightening for the individual, with mealtimes and eating accompanied by high levels of anxiety and intrusive, worrying thoughts. Difficulties with eating very often get in the way of normal daily activities, both because of physical consequences (e.g. not having enough energy) and because of the difficulty inherent in managing eating difficulties in the course of a 'normal' lifestyle. So, being able to develop a healthy pattern or eating is a crucial step in enabling an individual with an eating disorder take part in life again.

Therefore, part of achieving a healthy pattern of eating requires learning to manage such difficult thoughts and feelings. Different techniques have been developed in attempt to help individuals to be able to engage in a healthy pattern of eating. CAEDS already offers therapist-supported meal therapy, in which the presence of a trained member of staff is intended to help the individual manage their anxiety and fears around food to achieve the goal of eating to their dietitian-designed meal plan. Similarly, CAEDS and other services work with appropriate family members and friends to enable them to support individuals with eating disorders in this way (e.g. Treasure, Smith and Crane, 2007). However, these types of techniques are clearly dependent on the presence of another person; when these people are not available the individual with an eating disorder is inevitably left on their own.

For this reason, attempts have been made to develop alternative methods of supporting individual with eating disorders around food and meal-times, with a particular emphasis on helping the person do this for him or herself when he or she feels ready to do so.

One method has been to produce audio recordings of phrases and ideas that reiterate and support those messages developed with the individual during psychotherapy sessions for managing difficult thoughts and feelings, including relaxation techniques and 'arguments against eating-disordered thoughts'. Although there appears to be very little formal research exploring the use of such a tool, there are clear reasons why it could offer individuals with eating disorders real therapeutic benefit. We have gathered anecdotal evidence of the success of such an approach from a service in New Zealand (Becker, n.d.), and would like to explore its application within our service, with particular interest in developing and observing uptake of a Welsh-language version. Such a tool could be easily disseminated to other services to reach those individuals who are not currently clients of CAEDS, particularly those who do not currently meet the criteria for an eating disorder but are displaying signs of having difficulties around food and eating. Being able to offer such a resource to primary care practitioners we would not only be able to reach more individuals, sooner but could serve to strengthen links between clinicians and by offering busy GPs specialist support for distressed individuals that can be 'dispensed' in the same way as books in the Book Prescription Service.

If successful in bidding for this bursary, we will be able to work with clients and carers to develop audio-based meal support and to make this available on portable MP3 players to individuals with eating disorders to support them in developing healthy patterns of eating. An accompanying booklet would also be produced and disseminated to carers.

The MP3 players and accompanying booklet will be made available to services other than CAEDS, particularly primary care practices.

Outcomes will be evaluated through both behavioural outcomes (i.e. change to meal / eating habits) and emotional functioning measures (e.g. psychological adjustment to the idea of a 'healthy eating pattern' etc). The primary method of evaluation will be through evaluation forms completed by service-users, but additional feedback will be sought from carers and practitioners.

A sample budget is given below; the majority of the proposed expenditure is for the MP3 players and booklets, which cannot currently be subsumed within our service's budget.

RATIONALE

Benefits for clients

- It presents EXTERNAL prompting but does not rely on the availability and presence of another person. Locus of control and / or decision making can be difficult for some individuals with eating disorders, which includes deciding to eat and finish a meal; hearing a voice taking this decision instead takes the anxiety that emerges from the responsibility of having to do this at the beginning of therapy 'out of the equation'.

- A human voice can be more 'authoritarian' and harder for the individual with an eating disorder to 'disobey' (and to follow 'eating disordered thoughts' such as 'don't eat'), BUT will not evoke the same difficult interpersonal feelings as are prompted by having another person present

- It is not contingent on literacy levels etc (more accessible to different individuals)

- Doesn't need the client to have to actively concentrate to the same level as reading, but at the same time can be more distracting and therefore override 'eating disorder thoughts' that put barriers in the way of the person being able to eat. It can be hard *not* to listen something in contrast to it being easy not to read something!

- The individual with the eating disorder has control over what he or she listens to (or whether he or she listens to it), rather than being told to by another person. This is more likely to be acceptable to the individual with the eating disorder

- Its novelty may appeal to clients (especially younger clients), which may improve take up / acceptability of services and foster the therapeutic relationship with clinicians

- It can enable an individual to re-establish healthy eating patterns and thus re-gain physical and emotional health

- An MP3 can be used hands-free and therefore can involve minimum disruption to the meal

Benefits of audio files for carers

- Not contingent on literacy levels / eyesight / glasses etc (which can be of concern for older adults)

- It has a novel factor that may appeal to some carers

- It promotes choice, e.g. about therapy type

- It lowers the 'pressure' (and emotional consequences of this) on carers during meal times

- The content of the audio files can illustrate to carers what difficulties the individual with an eating disorder is likely to be facing during difficult meal times

- The accompanying booklet can help explain to carers the rationale underpinning the non-judgemental stance behind successful meal-therapy, and therefore could potentially be used by carers to develop their own meal-therapy skills

Benefits for Primary Care practitioners in particular

- It is a relatively self-explanatory resource that may be given to individuals by time-pressed practitioners with only a short introduction
- Its novelty may appeal even to those individuals who have lived with an eating disorder for a long time; this may have the additional effect of helping to 're-engage' individuals who have become dissatisfied with apparent lack of progress
- It is tied in with specific, observable behavioural outcomes (being able to eat a meal) that have in themselves clear physical health benefits

SATISFYING WaMH in PC criteria under *Category 1, "Enabling recovery and social inclusion"*

NSF 1: Social inclusion, health promotion and tackling stigma
Recovery from an eating disorder is contingent on establishing a healthier pattern of eating and relationship to food and eating. The ultimate aim of this audio-based meal therapy would be to help the individual achieve these goals. In addition to this, used to illustrate presentations to other services, the audio files present a novel, touching and interesting way of demonstrating the types of difficulties faced on a day to day basis by individuals with eating disorders and would help tackle the preconception that 'it is all about food'.

NSF 2: Service user and carer empowerment
The impetus behind the project has emerged from direct work with individuals with eating disorders, and observing the difficulties many CAEDS clients have found in trying to establish a healthy eating pattern. Where appropriate, we would hope to involve service users in the development of the content but also potentially (depending on who is open to the service at the time of production) inviting service users to deliver the spoken part of the audio files. The accompanying booklet will be made available to carers.

NSF 3: Promotion of opportunities for a normal pattern of daily life
The planned outcome of the use of these audio files by individuals with eating disorders would ultimately be that they would be able to begin to develop a healthy pattern of eating; this is a skill that underpins being able to have 'normal' way of life, particularly for those with eating disorders. The MP3 players may be used in normal, 'everyday' situations, allowing the person to be rather more independent than they would be if reliant on the presence of a family member or carer.

Gold Standard Attribute 2: Recovery through services that have the appropriate values and evidence base
We are a new and developing services, whose remit is to strongly promote and develop evidence based and best practice – drawing on NICE guidelines, NPHSW Eating Disorder Framework for Wales, and forthcoming Intelligent Targets. We are committed to good clinical governance and research as a routine part of our practice. Psychoeducation is an established part of therapy for eating disorders. Anxiety-management skills are also an established part of therapy for eating disorders. Thus, the content of the audio files would be based around those areas that have been proven to facilitate individuals to establish a health pattern of eating – one fundamental part of recovery from an eating disorder.

Gold Standard Attribute 3: Research and Development
There is currently minimal evidence beyond anecdotal accounts regarding the use of audio files in this way, but anecdotal evidence and observations of the practical difficulties inherent in more 'traditional' (often paper-based) modes of therapy suggest that an audio format may be a useful opportunity to draw upon. However, in order to improve the evidence-base around such tools, an important part of this project would be to conduct research-standard evaluations of its use.

Gold Standard Attribute 4: Good practice by engaging with individuals
We are always trying to develop better ways of working with individuals who come to our service, and we feel that these audio files and MP3s would offer a novel choice that may really appeal to individuals, particularly those who have had previous engagement with many other services and for whom motivation to manage meal times healthily is quite low.

METHODS AND SAMPLE TIME-LINE

Preparation: December 2010 – March 2011
Pilot the MP3s: March – June 2011

December 2010:	Working group to design content and music
	Fine-tune practical organisation *(e.g. length of lending; how to recover MP3 players; type of MP3 players; consider other options (e.g. CDs); how to offer and recover evaluation forms; detail of outcome measure)*
	Buy MP3 players
	Decision made about speaker
	Book recording studio and speaker
January / February 2011:	Record content
	Transfer onto MP3 players
	Advertise to CMHTs, GP surgeries
	Design accompanying leaflet
	Print leaflet and prepare evaluation forms
March 2011:	Disseminate leaflet, MP3s and evaluation forms
April 2011:	Retrieve first MP3s and evaluation forms
June 2011:	Retrieve all 'pilot' MP3s and evaluation forms
June to July 2011:	Analyse evaluation forms (questionnaire measures for our clients)
August 2011:	Prepare and disseminate report Aug 2011

COSTINGS

25-50 MP3 players
30 spare MP3 players
Half day in recording studio
Printing for 1000 A5 leaflets, 12 pp
Printing for 500 A5 1-sided leaflets for 'advertising' the files
Cost of translation

PLANNED OUTCOMES

Change in behaviour appropriate to individual's difficulties (e.g. eating more or finishing a meal after a satisfying portion)

Opinion / attitude measures regarding acceptability of the tool

Measures of emotional adjustment in relation to behavioural changes; other measures of psychological functioning

REFERENCES

(Becker, K. (n.d.),. Development of an Audio MP3 Meal Support Resource for Adolescents with Anorexia Nervosa.
Retrieved 22 October 2010, http://nutrition.otago.ac.nz/__data/assets/file/0015/5604/KBecker_SoF.pdf

National Institute for Clinical Excellence (2004) Eating Disorders: National Clinical Practice Guideline Number CG9. The British Psychological Society & The Royal College of Psychiatrists, 2004. *Retrieved 22 October 2010, http://www.nice.org.uk/nicemedia/live/10932/29220/29220.pdf*

Treasure, J., Smith, G. and Crane, A. (2007). Skills-based learning for caring for a loved one with an eating disorder: The new Maudsley method. London